



REQUEST FOR SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SPECIAL HEALTH SERVICES

SFN 1103 (07-2026)

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Field Data](#)

INSTRUCTIONS: Complete form in its entirety.

Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification, failure to disclose this information will not affect the disclosure of information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

SECTION 1. CLIENT INFORMATION

Name of Client		Social Security Number		Date of Birth	
Race: Select One ☐ White ☐ Black ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Asian ☐ Other-Specify: _____					
Ethnicity: Select One ☐ Non-Hispanic ☐ Hispanic ☐ Hispanic Origin Unknown				Sex: Select One ☐ Male ☐ Female	
Is child receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No					
Specify the Services Your Child Currently Has: Select all that Apply ☐ Individualized Education Program (IEP) ☐ Individualized Health Plan (IHP) ☐ 504 Plan					
Child's Grade in School		Name of Parents			
Address			City		State ZIP Code
Home Telephone Number		Work Telephone Number		Cell Telephone Number	
Health Care Coverage: Select all that Apply ☐ Medicaid ☐ Healthy Steps, CHIP ☐ Indian Health Service (IHS) ☐ Other Private or Public Insurance ☐ No Source					
Primary Insurance Company		Policy Date: Month/Day/Year		Policy Number	
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Concerns regarding the application process or authorized services should be sent in writing to:

Special Health Services
Department of Health and Human Services
600 E Boulevard Ave - Dept 325
Bismarck ND 58505-0200

For questions call Special Health Services at: 1-800-755-2714; TTY: 711

COMPLETE PAGE TWO

SECTION II. FINANCIAL COVERAGE APPLICATION

Assistance Requested for the Following Medical Conditions:

Services: ☐ Diagnostic Services ☐ Treatment Services ☐ Both

I understand that Special Health Services (SHS) does not cover sums for which there is any type of insurance coverage; or for which there is a recovery of money relative to the physical or medical condition for which application is made and that SHS is to be reimbursed for any payment for which recovery of funds is secured. I agree that the payment of any sums by SHS for services which are covered by insurance or may be recoverable because of the legal liability of a third party, will result in an automatic assignment to SHS of any claim for such sums and I hereby agree to such an assignment. I have read this application or had it read to me, and certify that all statements herein are true to the best of my knowledge.

Signature of Applicant	Date
Relationship to Client or Applicant	County
Signature of SHS Claims or Eligibility Administrator	Date

Disposition of Application - To Be Completed by State Office Only

☐ Approved ☐ Not Approved Because: _____	Effective Date
Signature of Medical Director or SHS Designee	Date